

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 6 7 5 0	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Alice Pearl ADAMS			2a. DATE OF DEATH MONTH DAY YEAR October 12, 1981		2b. HOUR 1710P. M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE W.Va.			13b. COUNTY Tucker	13c. CITY OR TOWN Thomas	
14. FATHER'S NAME FIRST MIDDLE LAST Frank ----- Cummings		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha ----- Wolfe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-36-9233		17. INFORMANT Mrs. Barbara Stieringer, Aurora, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Respiratory Arrest & Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) Massive Anterior MI and DUE TO, OR AS A CONSEQUENCE OF (c) D.C.V.A. w/ Hyperthermia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Hours Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/16/81 to 10/12/81, that (I) (we) lost saw the deceased alive on 10/12/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Gregory H. Pinkerba		22c. DATE SIGNED 10/13		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory H. Pinkerba	
22e. ADDRESS Egdon, West Virginia					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/16/81		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION CITY OR TOWN Thomas, Tucker, West Virginia		23e. DATE REC'D. BY REGISTRAR OCT 19 1981			
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		24b. ADDRESS Oakland, Maryland 21550		25a. REGISTRAR'S SIGNATURE James Van Natten	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Edwin Eugene BARMANN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 11, 1981</b>		2b. HOUR <b>9:15a.m</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Accident</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Highlander Estates</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Refridgeration</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Accident</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>---</b>		13f. STREET ADDRESS <b>(P.O. Box 41)</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>George Bargmann</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Evans</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>P.O. Box 41</b> <b>Virginia N. Bargman, Accident, Md. 21520</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> <b>4960</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>5 years.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Cor Pulmonale</b>							
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1</b> , 19 <b>80</b> , to <b>October 11</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>October 9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Walter K. Naumann</b>		DEGREE <b>MD.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-11-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter K. Naumann</b>		22e. ADDRESS <b>Accident, Md. 21520</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 14, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>Walter K. Naumann</b>		ADDRESS <b>Garrettsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 7 5 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mahlon BROWN			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1981		2b. HOUR 8:48a.m.
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Road Worker		12b. KIND OF BUSINESS OR INDUSTRY County Roads
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Garrett	13c. CITY OR TOWN McHenry	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Peter Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Georg		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-4543		17. INFORMANT ADDRESS Route 1, Box 18 Alice Brown -wife- McHenry, Md. 21541	

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Atherosclerotic Cerebrovascular Disease</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from <u>1977</u> , 19 <u>9-30-77</u> , to <u>10-21</u> , 19 <u>81</u> , that (1) <input checked="" type="checkbox"/> saw the deceased alive on <u>9-30-77</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.	
22b. SIGNATURE <u>George B. Stoltzfus</u>	22c. DATE SIGNED 10-21-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus	22e. ADDRESS Box 67 Friendsville, Md 21531

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 23, 1981	23c. NAME OF CEMETERY OR CREMATORY Addison Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Addison, Somerset, Pa
24. FUNERAL DIRECTOR NAME ADDRESS <u>James Neuman</u> Grantsville, Md.		25a. DATE RECEIVED BY REGISTRAR OCT 26 1981	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Lee Bucklew</b>			2a. DATE OF DEATH MONTH <b>October</b> DAY <b>30</b> YEAR <b>1981</b>		2b. HOUR <b>0815</b> A <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH DAY <b>22</b> MONTH <b>8</b> YEAR <b>26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.	
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrett Co. Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>WV</b> COUNTY <b>Preston</b> CITY OR TOWN <b>Terra Alta</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>Maple Ave. &amp; Park Rd.</b>			
14. FATHER'S NAME FIRST <b>Albert</b> MIDDLE <b>Bucklew</b> LAST <b>Bucklew</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ludia</b> MIDDLE <b>J.</b> LAST <b>Rhodes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>236-32-5470</b>		17. INFORMANT ADDRESS <b>Maple Ave, Terra Alta, WV 26764</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stroke</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic Cardio Vasc disease</b> (c) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. W. Fedde</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. W. Fedde</b>				22e. ADDRESS <b>Oakland, Maryland 21550</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Friendsville, Garrett, Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>John K. Whitehair</b> ADDRESS <b>105 Highland Ave, Terra Alta, WV 26764</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 5 1981</b> REGISTRAR'S SIGNATURE <b>Frances Jan Nix</b>			





BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 7 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elmer Richard Cox</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-4-81</b>			2b. HOUR M <b></b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-19-98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b>				
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrett Co. Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ind. State Rd.</b>		
13a. STATE <b>WV</b>		13b. COUNTY <b>Preston</b>		13c. CITY OR TOWN <b>Aurora</b>		13d. STREET ADDRESS <b>P.O. Box 63, Aurora, WV 26705</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Cox</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>310-07-0960</b>		17. INFORMANT ADDRESS <b>John W. Cox, P.O. Box 63, Aurora, WV 26705</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>4289</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Failure and Renal Failure.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>3 days</b> <b>Chronic</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Azotemia, Hyperkalemia</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/2</b> , 19 <b>81</b> , to <b>10/4</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10/4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Gregory N. Pinkerton</b>			DEGREE <b></b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10/4/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory N. Pinkerton</b>			22e. ADDRESS <b>Box 8 Egdon WV 26716</b>							
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b. DATE <b>10-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Aurora Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aurora Preston, WV</b>			
24. FUNERAL DIRECTOR NAME <b>John K. Whitehair</b>			ADDRESS <b>Terra Alta, WV 26764</b>			25. DATE REC'D. BY REGISTRAR <b>OCT 8 1981</b>				
REGISTRAR'S SIGNATURE <b>James J. Nathan</b>										

MEDICAL CERTIFICATION

1-1-1

xx

1-1-1

1-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

xx

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

xx

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

12-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 8126755								
1. DECEASED NAME (TYPE OR PRINT) John Harvey CRAMER					2a. DATE OF DEATH MONTH DAY YEAR October 17, 1981					2b. HOUR 04:15 A
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 12, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.				
12. CITY OR TOWN OF DEATH Oakland		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				14. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE WV 16b. CITY OR TOWN Preston Bayard					17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS Box 16			
19. FATHER'S NAME FIRST MIDDLE LAST Henry Cramer					20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Feathers					
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		21b. SOCIAL SECURITY NO. 299-03-4526		22. INFORMANT ADDRESS Mrs. John (Maude) Harvey Cramer, Bayard, WV Box 16, 26707						
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Ischemia 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Compensating Aortic Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4y.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Tachycardia										
24a. DATE OF OPERATION		24b. CONDITION FOR WHICH OPERATION WAS PERFORMED				25a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		25b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
27a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION STREET CITY OR TOWN COUNTY STATE						
28. I certify that (I) (this hospital) attended the deceased from 1981, to 1981, that (I) (we) lost saw the deceased alive on 10/16/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
29a. SIGNATURE B. L. Grant				29b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		29c. DATE SIGNED 10/17/81				
30a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. L. Grant				30b. ADDRESS Oakland, Maryland 21550						
31a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		31b. DATE 10-20-81		31c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		31d. LOCATION CITY OR TOWN COUNTY STATE Bayard, Preston, WV				
32. FUNERAL DIRECTOR NAME John R. Whitehair		32b. ADDRESS 105 Highland Ave.		32c. DATE REC'D. BY REGISTRAR OCT 16 1981		32d. REGISTRAR'S SIGNATURE Name [Signature]				

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923-1924

1925

1926

1927

1928

1929

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26756	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony Joseph DelSignore</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 21 81</b>		2b. HOUR <b>7:00 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Feb 2 1955</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>26</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 21 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.					
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route #2, Box 51</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coal &amp; Const.</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Oakland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route #2, Box 51</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carmen Patsy DelSignore, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathleen Grace McMullen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>234-80-2780</b>		17. INFORMANT ADDRESS <b>Carmen P. DelSignore, Jr., Deer Park, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, left</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Atheromatous plaque formation</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>several hrs.</b> <b>Unknown</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Drug Abuse, well documented</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>				TITLE (SPECIFY) <b>acting Dep.</b>				DATE SIGNED <b>22 Oct 1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton, M.D.</b>				ADDRESS <b>Oak @ 5th Sts., Oakland, MD 21550</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>10/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Co. Mem. Gardens</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland, Garrett, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Bradley A. Stewart</b>				ADDRESS <b>Oakland, Maryland 21550</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1981</b>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 8 1 2 6 7 5 7									
1. DECEASED NAME (TYPE OR PRINT) <b>Lena Zora Pearl Fratz (Fratz)</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1981</b>		2b. HOUR <b>800 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.			
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cuppert-Weeks Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Garrett</b> 13c. CITY OR TOWN <b>Accident</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>None</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis - - - - - Adams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Jane Phillips</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-32-3536</b>				17. INFORMANT ADDRESS <b>Mrs. Martha Jane Shaffer, Oakland, Md. 21550</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 Myocardial Failure</b> IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic Brain Syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>6-1-77</b> , 19 <b>81</b> , to <b>10-13</b> , 19 <b>81</b> , that (I) <del>XX</del> lost saw the deceased alive on <b>10-7-81</b> , 19 <b>81</b> , and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XX</del> did <del>XX</del> view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>10-13-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. B. L. Grant, MD</b>				22e. ADDRESS <b>Third Street, Oakland, Maryland 21550</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>10/16/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland, Garrett, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Bradley A. Stewart Oakland, Maryland 21550</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



Page 1



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mason Jonas GLOTFELTY</b>				7. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 4 1981</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 28, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b>	
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Garrett County Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Oakland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Brison Harvey Glotfelty</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Catherine Thomas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>212-32-8211</b>		17. INFORMANT ADDRESS <b>Mrs. S. Evelyn Glotfelty same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Myocardial Infarction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
IMMEDIATE CAUSE (a) <b>4100</b>							Years
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardio-vascular disease</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes Mellitu; Previous myocardial infarction; Pulmonary embolism.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>1951</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>10-4-1981</b>			
22a. I certify that (I) (this hospital) attended to and deceased from <b>10-4-1981</b> to <b>10-4-1981</b> , that (I) (we) lost the deceased alive on <b>10-4-1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James H. Feaster, Jr.</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-4-1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James H. Feaster, Jr., M. D.</b>				22e. ADDRESS <b>107 S. 2nd. St., Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/7/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland Garrett Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home</b>				25. DATE RECEIVED BY REGISTRAR <b>OCT 7 1981</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Oakland, Md.</b>				25. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP.

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

X

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

X

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

10-1-1951

X

10-1-1951

10-1-1951

10-1-1951

X

10-1-1951

X

10-1-1951

10-1-1951

10-1-1951

10-1-1951

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VR A15 ME (5))  
15M7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		26 / 59											
1. DECEASED NAME (TYPE OR PRINT) <b>Leighton Wilburn Harvey</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 12 81</b>		3.30 a M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 17 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 12 81</b>		4.05 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Kitzmiller</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Star Rt</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer &amp; Coal Miner</b>				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Kitzmiller</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Star Rt</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel O. Harvey</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Grimes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214 12 3598</b>				17. INFORMANT ADDRESS <b>Mrs. Lillian Harvey Kitzmiller, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b>												<b>Unknown</b>	
4149 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LOST.													
(b) <b>Arteriosclerotic Cardio-Vascular Disease</b>												<b>Unknown</b>	
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
<b>Left cerebrovascular accident with right hemiparesis - 1978</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Herbert H. Leighton, M.D.</i>				TITLE (SPECIFY) M.D. acting Dep. MEDICAL EXAMINER				DATE SIGNED <b>12 Oct. 1981</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton, M.D.</b>				ADDRESS <b>Oak @ 5th Sts., Oakland, MD 21550</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10 14 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Mem. Gardens</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland Garrett Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>David A Burdock Kitzmiller, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1981</b>				25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Luther Columbus HETRICK			2a. DATE OF DEATH MONTH DAY YEAR 10 - 13 - 81		2b. HOUR 0410 a
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	7. # UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.		
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Various Emp.		
13a. STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Mt. Lake Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1404 Pittsburgh Avenue.	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Hetrick	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Samantha Wright		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-40-3771		17. INFORMANT 171 Diamond St. Bruce W. Hetrick, Frostburg, Md. 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> 2502 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Urinary Tract Infection</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <u>2502</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James Beecham MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. James Beecham		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 15, 1981	23c. NAME OF CEMETERY OR CREMATORY St. John's Luth. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Accident, Garrett, Md.	23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR <u>James Neuman</u>		ADDRESS Grantsville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 19 1981	
25b. REGISTRAR'S SIGNATURE <u>Frances Van Natta</u>					

BP

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

2198

2199

2200

2201

2202

2203

2204

2205

2206

2207

2208

2209

2210

2211

2212

2213

2214

2215

2216

2217



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 1 2 6 7 6 1									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Anna Elizabeth IDLEMAN					2a. DATE OF DEATH October 13, 1981			2b. HOUR 1849P. <sup>M</sup>	
3 SEX Female		4 RACE White		5 DATE OF BIRTH July 19 1914		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett Co. MD.			
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE W. Va		13b. COUNTY Grant		13c. CITY OR TOWN Mt. Storm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST Noah Stark					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Sharpless				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT ADDRESS William Idleman Mt. Storm, W. Va					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction or Pulmonary Embolus</u> <u>2829</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemolytic Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours More than one week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Hypertension and Severe Obesity</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5 Oct</u> 19 <u>81</u> , to <u>13 Oct</u> 19 <u>81</u> , that (I) <del>met</del> <sup>saw</sup> the deceased alive on <u>13 Oct</u> 19 <u>81</u> , and that in (my) <del>best</del> <sup>own</sup> opinion death occurred on the date and hour and from the causes stated above, (I) <del>met</del> <sup>did not</sup> view the body after death.									
21b. SIGNATURE <u>Karl E. Schwalm</u> MD					21c. DEGREE MD			21d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22a. DATE SIGNED 10/14/81									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Karl E. Schwalm					22c. ADDRESS Garrett Medical Group, Oakland, MD				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 10-16-81		23c. NAME OF CEMETERY OR CREMATORY Mt. Storm Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Storm Grant W. Va			
24. FUNERAL DIRECTOR NAME DAVID A. BURDOCK					ADDRESS KITZMILLER, Md.		25a. DATE REC'D. BY REGISTRAR OCT 22 1981		
					25b. REGISTRAR'S SIGNATURE <u>Thane J. [Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 6 1 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leola Hazel ISABEL				2a. DATE OF DEATH MONTH DAY YEAR October 10, 1981		2b. HOUR 05:35A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 08, 1933		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel F. Rodeheaver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Iva Friend			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-48-3390		17. INFORMANT ADDRESS Samuel E. Isabel, See #13 above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4241 IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Hepatitis or uncertain etio</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this <input checked="" type="checkbox"/> ) attended the deceased from <u>Oct 7, 1981</u> to <u>Oct 10, 1981</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>Oct 10, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas Johnson</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas Johnson				22e. ADDRESS Oakland, Md. 21550			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/12/81		23c. NAME OF CEMETERY OR CREMATORY Rodeheaver Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garrett, Maryland	
24. FUNERAL DIRECTOR NAME Bradley A. Stewart				ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR OCT 19 1981	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Nathan</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. DO NOT FILE.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WEST PHILADELPHIA STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE				1		26163			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>James F. Kemp</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>10 20 1981</b>		2b. HOUR <b>7:00 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>30</b> YEAR <b>1906</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>75</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH <b>10</b> DAY <b>20</b> YEAR <b>1981</b>		7d. HOUR <b>11:00 A.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.					
10. CITY OR TOWN OF DEATH <b>Friendsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Guard Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roofing Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Friendsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>F.</b> LAST <b>Kemp, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Lemon</b> MIDDLE <b>15236</b> LAST <b>15236</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>207-16-9522</b>		17. INFORMANT ADDRESS <b>Richard Kemp 371 Millet, Pl. Hills, Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Dis</b> Unknown DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>				TITLE (SPECIFY) <b>Act. Dep</b>				DATE SIGNED <b>20 Oct 81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton</b>				ADDRESS <b>Oak &amp; 5th St, Oakland, Md. 21550</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/23/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pleasant Hills/Allegheny/Pa/</b>			
24. FUNERAL DIRECTOR NAME <b>A.J. Bekavac</b> ADDRESS <b>Funeral Home 555 5th., Clairton, Pa.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 26 1981</b>				25b. REGISTRAR SIGNATURE <b>[Signature]</b>			

12

1



SECRET

SECRET

SECRET

1

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

1

12

SECRET

SECRET

1

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 G561 11/5/81 GAB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 6 7 6 4

FOR  
1. STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Harry</b>			2a DATE OF DEATH MONTH DAY YEAR <b>October-19, 1981</b>			2b HOUR <b>00:10AM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>January 09, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Gerrett</b> MD.			
10 CITY OR TOWN OF DEATH <b>Oakland</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrett County Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Mechanist</b>		12b KIND OF BUSINESS OR INDUSTRY <b>-Railroad</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lucius C. Lang</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta M. Hawk</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>War II</b>		17 INFORMANT <b>Mrs. Sonja Moon, Cumberland, Md. Daughter</b>		ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral-Vascular Accident</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Vascular Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unknown</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>Oct 17, 1981</b> to <b>Oct 19, 1981</b> , that (I) (we) last saw the deceased alive on <b>Oct 18, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Herbert H. Leighton, M.D.</b>					DEGREE <b>M.D.</b>		22c DATE SIGNED <b>19 Oct 81</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. H. Leighton</b>					22e ADDRESS <b>Oakland, Maryland 21550</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>10-21-1981</b>		23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>		
24 FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>					25a DATE REC'D. BY REGISTRAR <b>OCT 23 1981</b>		25b REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>		

BP.



100-21-200

100-21-200

100-21-200

100-21-200

X

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

100-21-200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura Jemima MORRIS				2a. DATE OF DEATH MONTH DAY YEAR 10 - 15 - 81			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 14 1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE W.Va.				13b. COUNTY Mineral		13c. CITY OR TOWN Elk Garden	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Rohrbach				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Barger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236 78 5098		17. INFORMANT ADDRESS Minor Morris Elk Garden, W.Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yr.</u> <u>yr.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-15</u> 19 <u>81</u> to <u>Oct</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8-15</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B. L. Grant</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-15-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. L. Grant		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-18-81		23c. NAME OF CEMETERY OR CREMATORY IOOF Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE ELK GARDEN MINERAL WVA	
24. FUNERAL DIRECTOR NAME DAVID A. Burdock		ADDRESS Kitzmiller, Md.		25a. DATE REC'D. BY REGISTRAR OCT 22 1981		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH										2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		2b. HOUR	
Thomas Taylor						NOELL		10		22		81		728p	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Cauc.		10 02 89		92						19		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Virginia		U.S.A.										Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Oakland		Garrett Memorial Hospital		Retired Cont.		Building									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Virginia		Arlington		Arlington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1030 S. 21st Street							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Steven		Molly												Demoss	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes		WW I		579-02-1821		Lucille Noell, 1030 S. 21st St., Arl., VA.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4860		Pneumonia, Bilateral						24 hours							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION CITY OR TOWN		COUNTY		STATE			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		MEDICAL EXAMINER									
Dr. Herbert Leighton		M.D. Act. Dep.		23 Oct 81											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Dr. Herbert Leighton		502 E. Oak St., Oakland, Md. 21550													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		10/26/81		Culpeper National Cem.		Culpeper, Virginia									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Ives Funeral Home, Arlington, Virginia				OCT 29 1981		Charles J. Smith									

Σίνι γίV

• • • U

24.15

## Iron

i i xiv

100 117

100 117

4422

1501

66

I

— 15 —

. V . r . . 11 tal. . 02 , 180 19-10

25170

THE UNIVERSITY OF CHICAGO

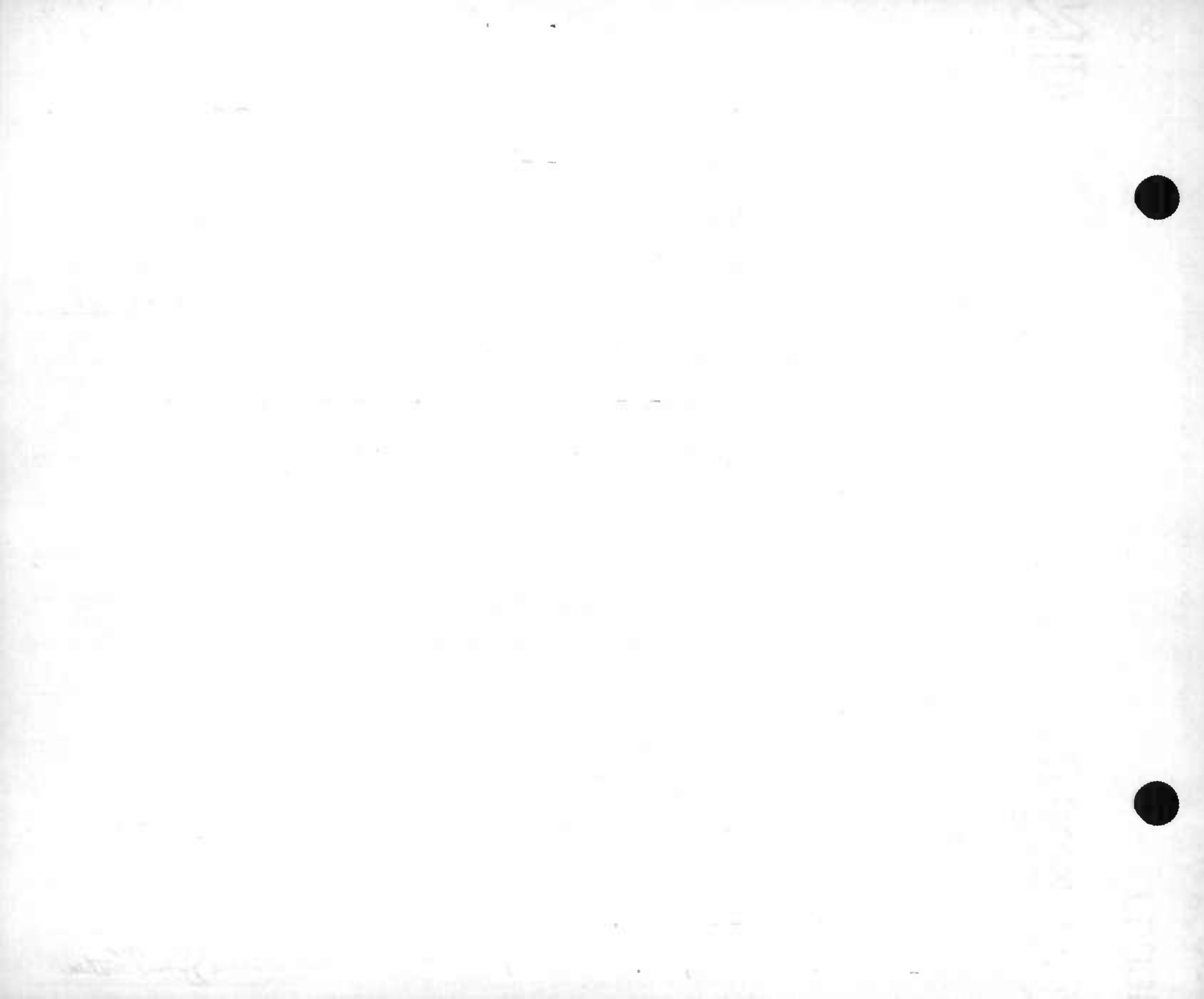
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-1222.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 26767			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NINA RUTH STITCHER				2a. DATE OF DEATH MONTH DAY YEAR 10-2-81		2b. HOUR 2:50 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-2-1892		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH GARRETT MD.	
10. CITY OR TOWN OF DEATH GRANTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MENNONITE GOODWILL NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. CITY OR TOWN COLLEGE PARK		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 7015 FORDHAM COURT	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES ROBBY JOHNSTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE SHIRES SHARTIZER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-32-9584		17. INFORMANT ADDRESS MILDRED S. GARLITZ CUMBERLAND, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D.		22c. DATE SIGNED 10-2-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-5-1981		23c. NAME OF CEMETERY OR CREMATORY SS. PETER & PAUL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ALLIANY MD	
24. FUNERAL DIRECTOR NAME LEASURE-STEIN FUNERAL HOME, INC.				25. DATE REC'D. BY REGISTRAR OCT 13 1981			
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

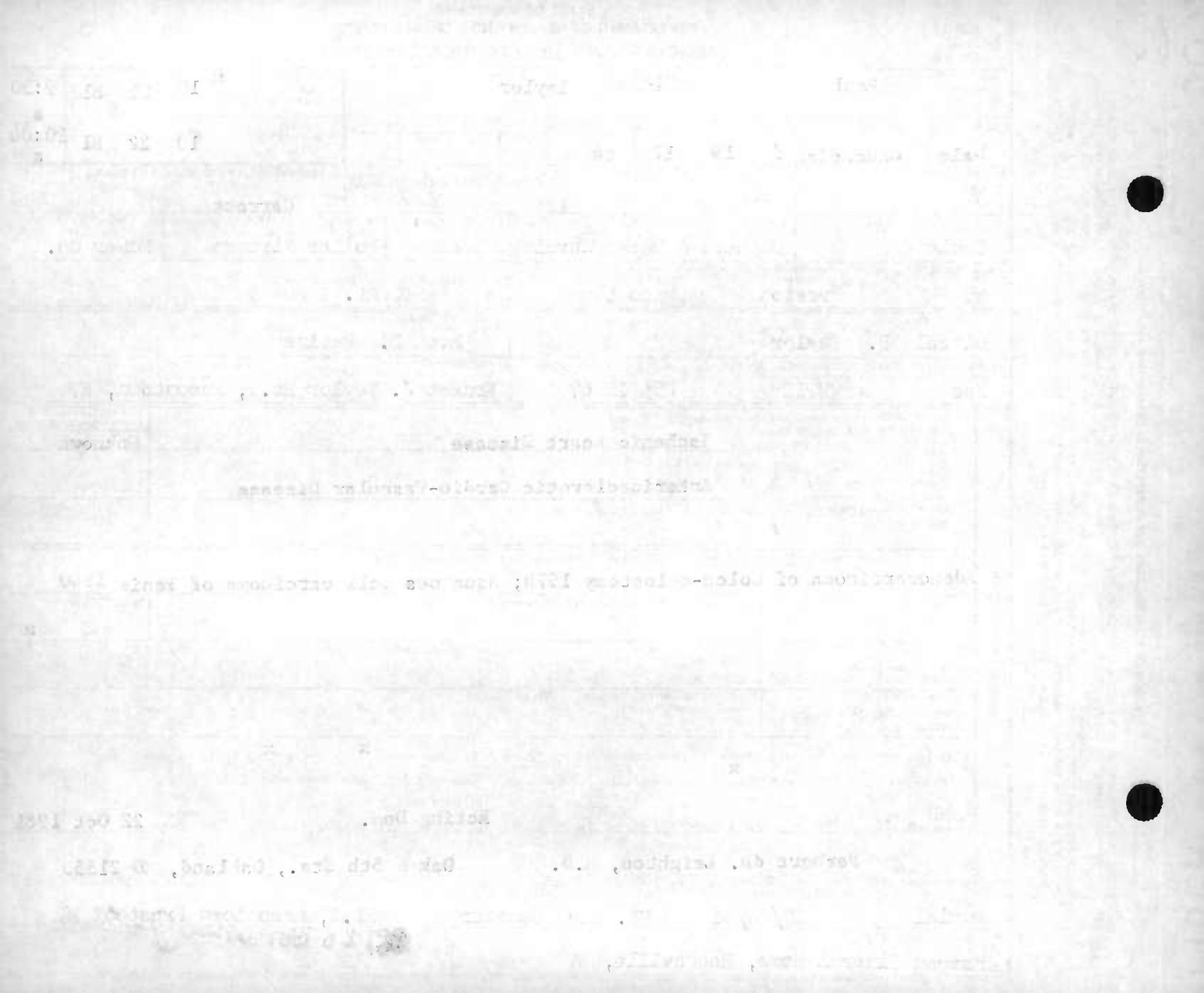




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES 1 AND 2 WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26768	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Mckinley Taylor</b>										2a. DATE KNOWN OF DEATH <b>10 22 81</b>	
3 SEX <b>Male</b> 4 RACE <b>Caucasian</b> 5. DATE OF BIRTH <b>5 19 17</b> 6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. DATE PRONOUNCED DEAD <b>10 22 81</b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b> 9b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.	
10. CITY OR TOWN OF DEATH <b>Oakland</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cuppett &amp; Weeks Nursing Home</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Boiler Fireman</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Power Co.</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>WV</b> 13b. COUNTY <b>Preston</b> 13c. CITY OR TOWN <b>Masontown</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>Rt. 1 Box 5</b>											
14. FATHER'S NAME <b>Oincel B. Taylor</b>										15. MOTHER'S MAIDEN NAME <b>Eva D. McKinney</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO. <b>235 14 6791</b>										17. INFORMANT ADDRESS <b>Ernest J. Taylor Rt.1, Masontown, WV</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Adenocarcinoma of Colon-colostomy 1978; Squamous Cell carcinoma of Penis 1980</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D. TITLE (SPECIFY) <b>Acting Dep.</b> MEDICAL EXAMINER										DATE SIGNED <b>22 Oct 1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton, M.D.</b> ADDRESS <b>Oak &amp; 5th Sts., Oakland, MD 21550</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>10/24/81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rt.1, Masontown Preston WV</b>	
24. FUNERAL DIRECTOR NAME <b>Morgan Funeral Home, Reedsville, WV</b> ADDRESS										25a. DATE OF REGISTRATION <b>26 1981</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Daniel TEETS					2a. DATE OF DEATH MONTH DAY YEAR October 09, 1981		2b. HOUR 11:05P M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH DAY MONTH YEAR Feb 27, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10 CITY OR TOWN OF DEATH Oakland,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Housing		
13a. STATE W.Va.			13b. COUNTY Preston		13c. CITY OR TOWN Tunnelton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 2	
14 FATHER'S NAME FIRST MIDDLE LAST Enos C. Teets				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charity Wiles						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-03-6249		17 INFORMANT ADDRESS Wilma P. Teets Rt 2 Bx 43 Tunnelton, WVa					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe chronic obstructive pulm. dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL INFARCTION</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> to <u>Oct 9</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Oct 9</u> , 19 <u>81</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not) (If not) review the body after death										
22b. SIGNATURE <u>Jared Zelman</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-12-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jared Zelman					22e. ADDRESS Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 12 1981		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kingwood Preston W.Va.			
24 FUNERAL DIRECTOR NAME <u>John K. Whitehair</u> ADDRESS Terra Alta, WVa					25a. DATE RECD BY Oct 11 1981					

11:52

October 22, 1964

11:52

11:52

11:52

11:52

11:52

11:52

11:52

11:52

11:52

11:52

11:52

11:52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26770	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mitchell Stephen Wathen</b>						2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 19 81</b>		2b. HOUR <b>10:05 a.m.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/28/1895</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>86</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Compton Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b> MD.					
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cuppert-Weeks Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Leonardtwn</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2 Box 35A</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Wathen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret M. Edwards</b>				16. ADDRESS <b>P.O. Box 276 Leonardtown, Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW I</b>		16b. SOCIAL SECURITY NO. <b>215-38-4380</b>		17. INFORMANT <b>Kenneth Wathen</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Rheumatic Valvular Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>Unknown</b> <b>Unknown</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>				TITLE (SPECIFY) <b>Acting Dep.</b>				DATE SIGNED <b>19 Oct 1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton, M.D.</b>				ADDRESS <b>Oak @ 5th Sts., Oakland, Md. 21550</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leonardtwn St. Marys, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Brinsfield Funeral Home</b>				ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1981</b>			
								25b. REGISTRAR'S SIGNATURE <b>Frances Jean Wathen</b>			

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 74 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1- STATE REGISTRAR												26771	
1. DECEASED NAME (TYPE OR PRINT) <b>Roy Edward WHITE</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>10 7 81</b>		2b. DATE PRONOUNCED DEAD <b>10 7 81</b>		2c. HOUR <b>8:46 p.m.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1910</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>71 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>10 7</b>		IF UNDER 24 HRS. HOURS MIN. <b>8 46</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Garrett</b>				
10. CITY OR TOWN OF DEATH <b>Oakland</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrett County Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>				
13a. STATE <b>Md.</b>			13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Mt. Lake Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>812 Deer Park Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wesley White</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Ellen Hoff</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-28-6889</b>			17. INFORMANT ADDRESS <b>Mrs. Mildred L. White, See #13 above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4149 IMMEDIATE CAUSE (a) Ventricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Ischemic Heart Disease</b> (c) <b>Arteriosclerotic Cardio-Vascular Disease</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>several years</b> <b>Unknown</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Diabetes Mellitus</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Herbert H. Leighton, M.D.</i>				TITLE (SPECIFY) <b>M.D. Acting Dep.</b>				DATE SIGNED <b>8 October 81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Herbert H. Leighton, M.D.</b>				ADDRESS <b>Oak @ 5th Sts., Oakland, Md. 21550</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>10/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Terra Alta, Preston, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Bradley A. Stewart</b>				ADDRESS <b>Oakland, Maryland 21550</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Handout 11: Leibniz's Law

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
Paul Edward WOLFE					October 08, 1981				10:25P M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White		August 06, 1921		60 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Garrett MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Oakland		Garrett County Memorial Hospital			Sheetmetal Mech.		Aerospace		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Garrett		Oakland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #1, Box 360-C	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Daniel Edward Wolfe					Edna Mae Lewis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
Yes					WW II		Mrs. Betty D. Wolfe, See #13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD sp m i</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Dm</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
10/5/80		Pericardial Disease			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 8</u> , 19 <u>81</u> , to <u>Oct 8</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Oct 8</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Th. Johnson</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			10/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Dr. Thomas Johnson					Oakland, Md. 21550				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		10/11/81		Garrett Co. Mem. Gardens		Oakland, Garrett, Maryland			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Bradley A. Stewart Oakland, Maryland 21550					OCT 14 1981		<u>Howe</u>		

